

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 6604

STATE FILE NUMBER 63-047967

FILED DEC 19 1963

1. PLACE OF DEATH a. COUNTY <u>Crawford, James E. Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Morris</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		c. CITY OR TOWN <u>Council Grove</u>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Menorah Medical Center</u>		d. STREET ADDRESS (If outside, give location) <u>Unknown</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>E.</u> Last <u>Crawford</u>		4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-3-95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oil Distributor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil</u>	
11a. FATHER'S NAME <u>Thomas Crawford</u>		11b. MOTHER'S MAIDEN NAME <u>Ada Rowan</u>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		12b. SOCIAL SECURITY NO. <u>Unknown</u>	
13a. NAME OF HUSBAND OR WIFE <u>Myra Crawford</u>		13b. NAME OF HUSBAND OR WIFE <u>Myra Crawford</u>	
14. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural Hematoma</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Intracerebral Hematoma</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Unknown</u>	
20c. TIME OF INJURY Hour <u>11</u> a.m. <u>27</u> p.m. <u>63</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>12-4-63</u>	
21. I attended the deceased from <u>11-27-63</u> to <u>12-4-63</u> and last saw her alive on <u>12-4-63</u>		21. I attended the deceased from <u>11-27-63</u> to <u>12-4-63</u> and last saw her alive on <u>12-4-63</u>	
22a. SIGNATURE (Degree or title) <u>Dewey K. Ziegler M.D.</u>		22b. ADDRESS	
22c. DATE SIGNED <u>12-6-63</u>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12/6/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Emporia Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Emporia, Kansas</u>		23d. LOCATION (City, town, or county)	
24. FUNERAL DIRECTOR <u>R.A. Fulton, Kansas City, Kansas</u>		25. DATE RECD. BY LOCAL REG. <u>12-6-63</u>	
26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>		26. REGISTRAR'S SIGNATURE	

DOCUMENT

Dewey K. Ziegler MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK  
OR  
TYPEWRITER RIBBON

VS 300  
Rev. 4/59

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28150

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99369

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11 333

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DEC 23 1963

JAN 7 1964

DE 3-2891

DEC 30 1963

DEC 26 1963

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Cass H. Dickel

Licensed Embalmer No. 5411

P. O. Address 722 Kousner

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.